Clinical Policy: Physical Rehabilitation Equipment and Supplies

Reference Number: WNC.CP.108 Coding Implications
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See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Durable Medical Equipment (DME) is primarily and customarily used to serve a medical purpose, is generally not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.
Medical Supplies are health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Physical Rehabilitation Equipment and Supplies are medically necessary when **ALL** the following requirements are met:
- A. The item is ordered by a Physician, Physician Assistant, or Nurse Practitioner
- B. The item is medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any noninstitutional setting in which normal life activities take place.
  1. Medical necessity must be documented by the prescriber (Physician, Physician Assistant, or Nurse Practitioner), for every item provided regardless of any requirements for approval. A letter of medical necessity written and signed by the Physician, Physician Assistant, or Nurse Practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted.
- C. A documented face-to-face encounter with the beneficiary and the ordering Physician, Physician Assistant, or Nurse Practitioner related to the primary reason the beneficiary requires durable medical equipment and medical supplies has occurred no more than six (6) months prior to the initiation of durable medical equipment and medical supplies.
- D. The beneficiary's need for durable medical equipment and medical supplies is reviewed by the ordering Physician, Physician Assistant, or Nurse Practitioner at least annually.

II. It is the policy of WellCare of North Carolina® that convenience items or features of Physical Rehabilitation Equipment and Supplies **are not** covered.

III. Prior Authorization Requirements: Refer to the Durable Medical Equipment and Supplies fee schedule at https://medicaid.ncdhhs.gov/ to determine if prior approval is required. WellCare of NC does not require prior authorization for items with a purchase price less than $500. **ALL** rental (and rent-to-purchase) items require prior authorization.

Background[1]

I. It is the policy of WellCare of North Carolina® that Durable Medical Equipment and Medical Supplies refers to the following categories of equipment and related supplies:
   A. **Inexpensive or Routinely Purchased**:
      1. These items are purchased for a beneficiary.
   B. **Capped Rental or Purchased Equipment**:
      1. These items are rented or purchased as follows:
         a. The item is rented if the Physician, Physician assistant, or Nurse Practitioner documents that the anticipated need is six months or less;
         b. The item may be **rented** or **purchased** if the Physician, Physician Assistant, or Nurse Practitioner documents that the anticipated need exceeds **six months**. Once rental is initiated on an item, a subsequent request for approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach the allowable purchase price.
   C. **Equipment Requiring Frequent and Substantial Servicing**:
      1. These items are rented; oxygen and items dealing with oxygen delivery are in this category.
   D. **Related Medical Supplies**:
      1. Supplies are covered when they are provided for use with medical equipment owned by the beneficiary.
   E. **Service and Repair**:
      1. The service and repair of medical equipment owned by a beneficiary is covered over the useful life of the item.
   F. **Individually Priced Items**:
      1. These items are reviewed on an individual basis and manually priced.

II. Servicing and Repairing Medical Equipment

   A. **Service and repair of medical equipment is handled in one of three ways**:
      1. **Rental Equipment**: Service and repairs are provided as part of the rental arrangement with no additional charge to the plan.
      2. **Purchased Equipment Warranty**: Service and repairs are handled under any warranty coverage an item may have. If there is no warranty, providers may request prior approval to perform the needed service and repairs. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery of the item or for the assembly of reimbursed parts.
      3. **Purchased Equipment Non-Warranty**: Service or repair is covered if the equipment is owned by the beneficiary and if the repair is not covered under the warranty. A repair estimate must be provided. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery,

for the assembly of reimbursed parts or for freight or the provider's travel time or expenses. **All** of the following information must be submitted:

a. The description and HCPCS code of the item being serviced or repaired;
b. The age of the item;
c. The number of times the item has been previously repaired;
d. The current replacement cost.

Note: Providers shall have emergency repair service available 24-hours a day, seven days a week for any life-sustaining equipment they provide.

Note: The plan shall not cover maintenance or service contracts.

III. Replacing Medical Equipment

A. The plan may consider replacing the item, when repairing is no longer cost-effective and the item is out of warranty.
B. When requesting prior approval for the replacement of an item before its usual life expectancy has ended, explain why the replacement is needed.
C. Specific documentation, in addition to the prescription, is required in the following situations:
   1. In cases of equipment loss or damage beyond repair, a letter from the social worker, case manager or child service coordinator explaining the circumstances.
   2. In cases of theft, a copy of the police report or a letter from the appropriate person with knowledge of the occurrence, such as the school principal, social worker, etc.
   3. In cases of equipment destruction by fire, a copy of the fire report.
   4. In cases of wide-spread natural disasters, documentation is accepted from any of the entities listed above or from the NC Division of Emergency Management, Federal Emergency Management Agency, American Red Cross, the National Guard or other appropriate state or local authorities and agencies on the ground in the affected areas.

IV. Durable Medical Equipment and Medical Supplies Limitations

A. The plan may place appropriate limits, based on medical necessity criteria, on Durable Medical Equipment and Medical Supplies. When the prescribing Physician, Physician Assistant, or Nurse Practitioner, orders equipment or supplies beyond these limits, the DME provider shall request the items through the usual process.
B. A request for an override of a quantity limit, or lifetime expectancy must contain the usual documentation along with the following additional information:
   1. The item being requested for an override clearly stated;
   2. The type of override (quantity limit, or lifetime expectancy) clearly stated;
   3. An explanation of the medical necessity for the override from the Physician, Physician Assistant, Nurse Practitioner, or Therapist.
C. Override requests are reviewed for medical necessity as per usual review timelines. Override review outcomes are communicated to providers and beneficiaries in the same way as a typical request.
D. To request a medical necessity review for an item not listed, see section **Requesting Unlisted DME and Medical Supplies for Adults** for instructions.

V. Requesting Unlisted DME and Medical Supplies for Adults

In compliance with the Centers for Medicare & Medicaid Services (CMS) Home Health Final Rule, 42 CFR Part 440.70, please follow these guidelines when requesting medical necessity reviews for DME and medical supplies for adults not listed below or the DME fee schedule.

A. The general requirements and criteria set forth in this clinical coverage policy must be met. This includes, but is not limited to:
   1. The item being requested must fit the definition of durable medical equipment or medical supplies;
   2. The item must be requested on a WellCare of NC member by a Medicaid enrolled provider;
   3. The requested item must be safe, effective, economical and not intended for the convenience of the beneficiary, the beneficiary's caregiver, or the provider;
   4. The item must be medical in nature, generally recognized as an accepted method of treatment, and must not be experimental or investigational;
   5. The item must be ordered by a Physician, Physician Assistant, or Nurse Practitioner; and
   6. The item must be medically necessary to maintain or improve a beneficiary's medical, physical or functional level, and appropriate for use in any non-institutional setting in which normal life activities take place;
   7. A documented face-to-face encounter with the beneficiary and the ordering Physician, Physician Assistant, or Nurse Practitioner related to the primary reason the beneficiary requires the item must have occurred no more than six months prior to the initiation of durable medical equipment or medical supplies; and
   8. The beneficiary's need for the item must be reviewed by the ordering Physician, Physician Assistant, or Nurse Practitioner at least annually.

B. If the provider determines that the applicable requirements and criteria set forth in this clinical coverage policy have been met, then the provider may submit a request and the usual supportive documentation for a medical necessity review.

C. Providers may request non-covered, unlisted or restricted items using their identifiable HCPCS code (e.g.: E1012). If no HCPCS code exists, providers may use the miscellaneous combination K0108/W4005 for wheelchair accessories only, and for non-wheelchair items, the miscellaneous combination E1399/W4047.

D. Items approved by this procedure may be manually priced. Please include the appropriate manual pricing documentation with the request.

E. Claims for items approved using this procedure should also be submitted.

F. If denied, the provider and beneficiary will be notified, and normal beneficiary appeal rights will apply.

Specific Medical Necessity Criteria[1]

I. It is the policy of WellCare of North Carolina® that **Hospital Beds, Pediatric Beds and Related Supplies** meet medical necessity as follows:

A. **Fixed Height Hospital Bed** is medically necessary when **one** of the following is documented:

1. The beneficiary's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections) in ways not feasible in an ordinary bed **or** the beneficiary's condition requires special attachments that cannot be attached to and used on an ordinary bed.

B. **Variable Height Hi-Lo Hospital Bed** is medically necessary when **one** of the following is documented:
   1. The beneficiary's condition requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections, etc., in ways not feasible in an ordinary bed **or** the variable height feature is necessary for the beneficiary to ambulate and transfer in and out of bed.

C. **Semi-Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
   1. The beneficiary's condition requires frequent change in body position; **and**
   2. There is an immediate need for a change in position and the beneficiary can operate the controls independently and make the adjustments.

D. **Total Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
   1. The beneficiary's condition requires frequent change in body position **or** there may be an immediate need for a change in position; **and**
   2. The beneficiary can operate the controls and make the adjustments; **and**
   3. The variable height feature must be medically justified.

E. **Oversized Hospital Bed** is medically necessary when **all** of the following criteria are met:
   1. Documentation submitted shows the beneficiary meets the medical necessity requirements for the comparable standard size equipment and the medical need for the oversized equipment
   2. The beneficiary's height, weight, and body measurements are included and meet the weight requirements specified in the HCPCS code requested. The body measurements must be taken in the appropriate position for the requested equipment (i.e. supine for hospital beds); **and**
   3. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment are included.

F. **Pediatric Cribs, Pediatric Hospital Beds, and Safety Enclosures**
   1. Covered when the beneficiary's diagnosis and medical condition deem it medically necessary. For approval **one** of the following criteria must be met:
      a. Documentation from the Physician, Physician Assistant, or Nurse Practitioner includes an order for the hospital grade crib, safety enclosure, or related supplies and documents that this is the most appropriate, medically necessary bed for the beneficiary;
      b. The beneficiary's condition requires positioning of the body (e.g. to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections) in ways not feasible in an ordinary bed or crib; **or**
      c. The beneficiary's condition requires a bed or crib with special attachments that cannot be attached to and used on an ordinary bed.
   2. Hospital grade cribs and safety enclosures are **not** considered medically necessary when used for:
      a. caregiver convenience

b. behavior therapy
c. physical restraint
d. substitute for appropriate parental; or caregiver supervision **or**
e. regular bed meets the needs of the beneficiary.

G. **Pediatric Specialty Beds** are beds, such as the Sleep Safe or Pedi craft beds, that have special safety features that prevent entrapment or falls. These beds are designed for children with physical and cognitive disabilities who require a safe enclosed padded interior that allows quick and easy access for frequent or sudden medical attention. These beds and accessories are covered when the beneficiary's diagnosis and medical condition deem it medically necessary.
   1. **All** the following criteria must be met:
      a. Documentation from the Physician, Physician Assistant, or Nurse Practitioner includes an order for the hospital grade crib, safety enclosure, pediatric specialty bed or related supplies and documents that this is the most appropriate, medically necessary bed for the beneficiary;
      b. The diagnosis and medical condition of the beneficiary must support the need for the additional features these beds offer, for example severe spasticity, thrashing or uncontrolled movements, cognitive impairment, unsafe activities or behaviors which place the beneficiary at risk for injury and make the use of a specialty bed necessary;
      c. A letter of medical necessity or clinical evaluation from a physical therapist or occupational therapist involved in the care of the beneficiary that includes:
         i. the specific detail to show how the requested equipment is medically necessary for the beneficiary; **and**
         ii. an explanation of why a regular bed or a hospital bed with rails and rail pads does not meet the beneficiary's needs. This includes a description of other less expensive specialty beds that were considered and ruled out and why they were ruled out.

      Note: The physical therapist or occupational therapist completing the letter of medical necessity and evaluation cannot be employed by or have a financial relationship with the medical equipment provider.
      d. The environment supports the use of a hospital grade crib, safety enclosure, or pediatric specialty bed and related supplies. Documentation must be included to demonstrate suitability in the environment and utilization for the beneficiary; **and**
      e. Documentation that the family or caregiver is willing and able to safely and appropriately use the equipment.
   2. Pediatric specialty beds are **not** considered medically necessary when used for:
      a. caregiver convenience
      b. behavior therapy
      c. physical restraint
      d. substitute for appropriate parental; or caregiver supervision **or**
      e. regular bed meets the needs of the beneficiary.

H. **Hospital Bed Related Supplies**
   1. **Replacement Mattress** or **Side Rails** for a hospital bed are covered when the following criteria are met:

a. there is evidence that the mattress or side rails is worn out or broken and must be replaced; **and**
b. continued use of an approved beneficiary-owned hospital bed is medically necessary.

2. **Trapeze Bar** is covered when the beneficiary requires the accessory to reposition himself or herself in an approved hospital bed.
3. **Traction Frame** is covered when the beneficiary requires traction for a specific orthopedic diagnosis and the equipment is ordered by a physician for use with an approved hospital bed.
4. **Bed Pan or Urinal** is covered when the beneficiary is unable to move from the bed to the bathroom or bedside commode for elimination.
5. **Bed Cradle** is covered if the beneficiary requires protection of a body part from topical pressure.
6. **Heavy-Duty Trapeze Bar** is covered when the beneficiary requires the accessory to reposition the beneficiary in an approved hospital bed and meets the weight requirement specified for the heavy duty trapeze bar. The beneficiary's weight must be documented.

II. It is the policy of WellCare of North Carolina® that **Pressure-Reducing Support Surfaces—Group 1** meet medical necessity as follows:

A. Group 1 Pressure-Reducing Support Surfaces (**including an alternating pressure pad, pressure reducing mattress overlay, or air or gel pressure pad**) are covered when they are medically necessary for the beneficiary.
   1. Group 1 Overlays or Mattresses are covered when the beneficiary meets **one** of the following criteria:
      a. The beneficiary is completely immobile, i.e. cannot make changes in body position without assistance, **or**
      b. The beneficiary has limited mobility, i.e. cannot independently make changes in body position significant enough to alleviate pressure, and has **one** of the following:
         i. impaired nutritional status
         ii. incontinent of feces or urine
         iii. altered sensory perception
         iv. compromised circulatory status **or**
         v. inability to respond to pain.
      c. The beneficiary has any stage pressure ulcer on the trunk or pelvis and has **one** of the following conditions:
         i. impaired nutritional status
         ii. altered mental status
         iii. incontinent of feces or urine
         iv. altered sensory perception **or**
         v. compromised circulatory status.

B. All Group 1 Support Surfaces must be rented when the anticipated need for the item is six months or less, except for the *Replacement Pad for use with medically necessary alternating pressure pad owned by beneficiary* and the *Dry Pressure Pad for Mattress, standard mattress length and width*; which are purchase-only items. The Group 1 Support

Surfaces may be rented or purchased when the Physician, Physician Assistant, or Nurse Practitioner documents that the anticipated need exceeds six months.

III. It is the policy of WellCare of North Carolina® that **Pressure-Reducing Support Surfaces—Group 2** meet medical necessity as follows:

A. Group 2 Pressure-Reducing Support Surfaces, including a **powered air flotation bed, powered pressure-reducing air mattress, or pressure reducing overlay**, are covered when they are medically necessary for the beneficiary.
   1. For initial approval of Group 2 support surfaces (maximum of six months), the beneficiary shall meet **one** of the conditions listed below:
      a. The beneficiary has the following:
         i. multiple Stage II pressure ulcers (ulcers with partial-thickness skin loss involving epidermis and/or dermis) located on the trunk or pelvis; **and**
         ii. the ulcers have worsened or remained the same over the past month; **and**
         iii. the beneficiary has been on a comprehensive ulcer treatment program for at least the past month, which has included the use of an appropriate Group 1 support surface. Comprehensive ulcer treatment includes the following:
      a. education of the beneficiary and caregiver on the prevention and management of pressure ulcers;
      b. regular assessment by a physician, physician assistant, or nurse practitioner, or other licensed healthcare practitioner (usually at least weekly for a beneficiary with a Stage III or IV ulcer);
      c. appropriate turning and positioning;
      d. appropriate wound care (for a Stage II, III, or IV ulcer);
      e. appropriate management of moisture or incontinence; and
      f. a nutritional assessment and intervention consistent with the overall plan of care.
      b. The beneficiary has large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis;
      c. The beneficiary has a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 calendar days) and has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 calendar days).
   2. Continued use of a Group 2 support surface is covered until the ulcer(s) is healed. If healing does not continue, there must be additional documentation in the health record to show:
      a. Other aspects of the care plan are being revised at least every four weeks to promote healing; and
      b. Use of the Group 2 support surface is medically necessary for wound management.

   All items are rented and only become the property of the beneficiary when the monthly rental payments reach the purchase price.

IV. It is the policy of WellCare of North Carolina® that **Pressure-Reducing Support Surfaces—Group 3** meet medical necessity as follows:

A. An **air fluidized bed** combines air fluidized therapy and low air-loss therapy on an articulating frame providing beneficiary with maximum relief from bed pressure. An air fluidized bed is covered when it is medically necessary for the beneficiary.

1. For initial approval the beneficiary shall meet **all** the following criteria:
   a. The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure sore, or is status post-op muscle/skin flap repair of a stage III or IV pressure sore
   b. The beneficiary is bedridden, or chair bound as a result of severely limited mobility;
   c. The air-fluidized bed is prescribed in writing by the beneficiary's attending physician based upon a comprehensive assessment of the beneficiary after conservative treatment has been tried without success. Conservative treatment includes **all** the following:
      i. education of the beneficiary and caregiver on the prevention and management of pressure ulcers
      ii. assessment by a Physician, Physician Assistant, or Nurse Practitioner, or other licensed healthcare practitioner done at least weekly
      iii. turning and positioning
      iv. use of a Group II support surface, if appropriate
      v. topical wound care
      vi. management of moisture or incontinence **and**
      vii. nutritional assessment and intervention consistent with the overall plan of care;
   d. The beneficiary shall have been on the conservative treatment program for at least one month prior to use of the air-fluidized bed with no improvement or worsening of the ulcer. The evaluation must be performed within a week of initiating treatment with the air-fluidized bed;
   e. A trained adult caregiver is available to assist the beneficiary with activities of daily living, fluid balance, dry skin care, repositioning, recognition, management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system;
   f. A Physician, Physician Assistant, or Nurse Practitioner directs the treatment regimen, and re-evaluates and recertifies the need for the air-fluidized bed on a monthly basis; **and**
   g. All other alternative equipment has been considered and ruled out.
2. An air-fluidized bed is denied as **not medically necessary** under any of the following circumstances:
   a. The beneficiary has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens secretions).
   b. The beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material.
   c. The caregiver is unwilling or unable to provide the type of care required by the beneficiary on an air-fluidized bed.
   d. Structural support is inadequate to support the weight of the air-fluidized bed system (it weighs around 1,600 pounds).
   e. The environment's electrical system is insufficient for the anticipated increase in energy consumption.
   f. There are other known contraindications to the use of this bed.

Note: Initial approval for an air-fluidized bed is given for a maximum of one month. Renewals are given for a maximum of one month. The documentation requirements are the same for requests to renew approval.

3. An air fluidized bed is typically needed only 6-12 weeks post-operatively. Continued use of an air-fluidized bed is covered until the ulcer is healed. If healing does not continue, there must be additional documentation in the clinical health care record to show:
   a. Other aspects of the care plan are being modified to promote healing; **and**
   b. The use of the air-fluidized bed is medically necessary for wound management.

V. It is the policy of WellCare of North Carolina® that **Manual Wheelchairs** meet medical necessity as follows:

A. A **Manual** Wheelchair is covered when all the following **basic criteria** are met:
   1. The beneficiary has a mobility limitation that significantly impairs the beneficiary's ability to participate in one or more mobility-related activities of daily living (MRADLs);
   2. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker;
   3. The beneficiary's environment is accessible for a wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided;
   4. Use of a manual wheelchair is reasonably expected to significantly improve the beneficiary's ability to participate in MRADLs; **and**
   5. The beneficiary has sufficient upper extremity function and the physical and mental capabilities needed to safely self-propel the manual wheelchair throughout the course of a normal day or has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

B. A **Standard Hemi** (low seat) Wheelchair is covered when **all the basic criteria (Section V.A.)** are met **plus** the following:
   1. The beneficiary requires a lower seat height (17 to 18 inches) because of short stature or to enables the beneficiary to place his or her feet on the ground for propulsion.

C. A **Lightweight** Wheelchair is covered when **all the basic criteria (Section V.A.)** are met **plus** the following:
   1. The beneficiary cannot self-propel in a standard wheelchair using his or her arms or legs;
   2. The beneficiary can and does self-propel safely and functionally in a lightweight wheelchair;
   3. The provider shall submit supporting documentation with the request that demonstrates the beneficiary has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair; **and**
   4. The beneficiary can safely propel the lightweight wheelchair.

D. A **High-Strength Lightweight** Wheelchair is covered when **all the basic criteria (Section V.A.)** are met **plus** the following:
   1. The beneficiary cannot safely and functionally self-propel in a standard or lightweight wheelchair using his or her arms or legs while engaging in frequent activities;
   2. The beneficiary spends a minimum of six hours each day in the wheelchair;

3. The beneficiary can safely and functionally self-propel in a high-strength lightweight wheelchair; **and**
4. The provider shall submit supporting documentation with the request that states the beneficiary has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair.

E. An **Ultra Lightweight** Wheelchair is covered when **all the basic criteria (Section V.A.)** are met **plus** the following:
1. The routine activities the beneficiary engages in cannot be performed in a lightweight wheelchair;
2. The features of the ultra-lightweight wheelchair are required for the beneficiary to be functional;
3. The beneficiary spends a minimum of six hours each day in the wheelchair; **and**
4. The beneficiary can safely propel the ultra-lightweight wheelchair.

F. A **Heavy-duty** wheelchair is covered when **all the basic criteria (Section V.A.)** are met **plus** either of the following:
1. The beneficiary weighs more than 250 pounds; **or**
2. The beneficiary has severe spasticity.

G. An **Extra Heavy-duty** wheelchair is covered when **all the basic criteria (Section V.A.)** are met **and** the beneficiary weighs more than 300 pounds.

H. A **Manual Adult Size** Wheelchair, which includes tilt-in-space, is covered when **all the basic criteria (Section V.A.)** are met **plus** coverage criteria for the tilt-in-space option. The following is required for medical necessity:
1. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier;
2. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the manual adult size wheelchair and all additional accessories requested; **and**
3. A MSRP quote for the requested wheelchair and accessories from the manufacturer.

I. For the **tilt-in-space feature**, the following criteria must be met:
1. The beneficiary requires the tilt in space feature for proper positioning during daily activities, such as eating;
2. The beneficiary has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment;
3. The beneficiary is unable to actively change his or her upright seating position and is at risk for loss of skin integrity;
4. The beneficiary has a respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature; **and**
5. The beneficiary must spend a minimum of six hours per day in the wheelchair to qualify for the tilt in space feature.

J. Adult and pediatric **transport** chairs, and a **roll-about** chair are covered when they are medically necessary for the beneficiary.

K. **Pediatric Manual** Wheelchairs and accessories are covered when they are medically necessary for the beneficiary. Approval is required for all pediatric wheelchairs. **Note**: Pediatric wheelchairs are covered only for a child or an adult of very small stature. The wheelchair width or depth must be 14 inches or less to be coded as pediatric. The following is required for approval:
   1. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier;
   2. A letter of medical necessity from the physical or occupational therapist that documents:
      a. the medical need for mobility;
      b. the medical need for the pediatric manual wheelchair selected and all the additional accessories requested;
      c. the environment's accessibility; **and**
      d. a MSRP quote for the requested wheelchair and accessories from the manufacturer.

L. **Oversized Manual** Wheelchairs for weights greater than 451 pounds are covered when they are medically necessary for the beneficiary. For approval, **all the basic criteria (Section V.A.)** must be met **plus** the following:
   1. The beneficiary shall meet the weight requirements for the specific wheelchair requested. The beneficiary's height, weight, and body measurements must be included with the request for approval; **and**
   2. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

VI. It is the policy of WellCare of North Carolina® that **Power Wheelchairs** meet medical necessity as follows:

A. The following information must be submitted with the approval request:
   1. A face-to-face examination which consists of an in-person visit to the beneficiary's treating physician for the purpose of requesting a power wheelchair and a comprehensive medical examination. The face-to-face examination must be documented in a detailed narrative note in the physician's chart in the same format used for other entries. The physician's note must clearly indicate the major reason for the visit was a mobility examination. The physician's note must document the beneficiary's strength, mobility and functional deficits, and support the need for a power wheelchair to perform MRADLs. The face-to-face evaluation must be completed prior to the physician's order for the power chair and must support the medical necessity for the power wheelchair. This evaluation must provide subjective and objective information about the beneficiary's condition and progression of the beneficiary's disease over time. It must clearly indicate the beneficiary's ambulatory status, explain why a power wheelchair is needed as compared to a cane, walker, or manual wheelchair and address the medical justification for each accessory billed. Other clinical health care records (physician office records, hospital records, home health agency records, or physical and occupation therapy notes) can be submitted to supplement the information in the face-to-face evaluation.

2. An onsite written assessment of the beneficiary's environment that verifies and documents the beneficiary's environment supports the use of a power wheelchair. The assessment can be performed by the wheelchair supplier and must include measurements of the physical layout of the environment, doorway widths, doorway thresholds, and surfaces the chair moves over.
3. A MSRP quote for the requested wheelchair and accessories from the manufacturer that gives a detailed description of the items requested.

   Note: A wheelchair supplier generated form must not be used to document the physician's examination since a supplier generated form is not considered to be part of the clinical health care record.

   Payment is made for only one wheelchair at a time. A backup wheelchair is not covered as it is not medically necessary.
4. A power wheelchair is **not medically necessary** when the underlying condition is reversible and the length of need is less than three months.

B. **Standard Power Wheelchairs**

1. Standard Power Wheelchairs, including Group 1 chairs and some Group 2 chairs without power options, are covered when they are medically necessary for the beneficiary. **All** the following coverage criteria must be met:
   a. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs;
   b. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker;
   c. The beneficiary does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform MRADL's throughout the course of a normal day. Limitations of strength, endurance, range of motion, coordination, presence of pain, deformities, or the absence of one or both upper extremities must be noted in the assessment of upper extremity function;
   d. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair and to assure it is cared for;
   e. Use of the power wheelchair is reasonably expected to significantly improve the beneficiary's ability to participate in MRADLs; **and**
   f. The beneficiary's environment is accessible to the wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the power wheelchair that is provided.

      Note: For this policy MRADLs are defined as toileting, feeding, dressing, grooming, and bathing. To be considered **significantly impaired** means the mobility limitation prevents performance of the activity entirely, prevents the activity from being completed in a reasonable time frame, or places the beneficiary at high risk for injury when performing the activity, or at a heightened risk of morbidity secondary to attempts to perform the MRADL.

C. **Complex Rehab Power Wheelchairs**

1. Complex rehab power wheelchairs, including power chairs with single or multiple power options, require approval. In addition to the face-to-face assessment with the physician, the onsite written assessment of the beneficiary's environment, and the manufacturer's quote required for all power wheelchairs, the following are required:

a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the beneficiary's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier; **and**
b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the complex rehab power wheelchair and all additional accessories requested.

2. Complex rehab power wheelchairs are covered if **all** the criteria for a Standard Power Wheelchair are met **plus** the following:
   a. The beneficiary requires a drive control interface other than a hand or chin operated standard proportional joystick;
   b. The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair. (Refer to Wheelchair Accessories, Power Seating Systems for approval requirements for power tilt and recline);
   c. The wheelchair clinic evaluation must document the medical necessity for the wheelchair and its special features;
   d. A Group 3 power wheelchair is covered when the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; **and**
   e. Group 4 power wheelchairs have added capabilities that are not usually needed for use in the home.

D. **Heavy Duty Power Wheelchairs**

1. Heavy duty power wheelchairs for beneficiaries who weigh more than 300 pounds are covered when they are medically necessary for the beneficiary. Approval is required. For approval of heavy-duty wheelchair all the following must be submitted:
   a. Documentation shall substantiate the following two requirements:
      i. beneficiary shall meet the weight requirements for the heavy duty power wheelchair requested; **and**
      ii. medical necessity for a comparable standard size wheelchair.
   b. The beneficiary's height, weight, and body measurements must be included.
   c. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

VII. It is the policy of WellCare of North Carolina® that **Wheelchair Accessories** meet medical necessity as follows:

A. **Batteries**

1. Batteries are covered when they are necessary to operate the power wheelchair that has been approved for the beneficiary. Battery Chargers are covered when the criteria for a power wheelchair are met. An initial charger must be included in the allowance for a power wheelchair. The charger must be billed separately only when it is a replacement.

B. **Armrests**

1. Adjustable Height Armrests are covered when the beneficiary requires an arm height that is different from those available using non-adjustable armrests, and the beneficiary

spends more than four hours per day in the wheelchair. Approval is required for adjustable height armrests.

2. Arm troughs are covered when the beneficiary requires additional support for the upper extremity not provided by the wheelchair armrest.

C. **Cushions**

1. General use wheelchair cushions are covered when the beneficiary has a diagnosis that causes deformities of the musculoskeletal system, has contractures such that the normal body alignment is significantly altered, and spends more than two hours per day in the wheelchair.
2. Positioning wheelchair cushions are covered when the beneficiary has the potential for development of a musculoskeletal deformity of the trunk, or has already begun to develop such a deformity, and it can be ameliorated or retarded by the addition of a positioning cushion.
3. Skin protection and positioning wheelchair cushions may be covered if the beneficiary has a diagnosis or condition that causes skin breakdown due to immobility in a wheelchair for long periods of time. The beneficiary shall be wheelchair bound.

D. **Headrests**

1. The beneficiary shall have **all** the following for approval of head and neck supports:
   a. Weakness or abnormal muscle tone in cervical musculature such that function in those muscles is significantly impaired and the headrest is needed to support the head; **and**
   b. The beneficiary is not able to actively maintain proper cervical positioning.

   A head and neck support is approved when the beneficiary has a reclining back on the approved wheelchair.

E. **Reclining Back**

1. A reclining back is covered when the beneficiary has **any** of the following:
   a. Severe trunk or hip bony deformity;
   b. Trunk or lower extremity casting or bracing the requires reclined positioning;
   c. Severe extensor tone of the trunk muscles;
   d. The need to rest in a recumbent position two or more times during the day and transfers between the wheelchair and bed are very difficult;
   e. Cannot tolerate upright positioning due to blood pressure instability; **or**
   f. Spends more than four hours per day in the wheelchair.

   Approval is required.

F. **Elevating Leg Rests**

1. Elevating leg rests are covered when the beneficiary has **any** of the following:
   a. A musculoskeletal condition which prevents 90-degree flexion at the knee;
   b. The presence of a cast or brace which prevents 90-degree flexion at the knee;
   c. Circulation issues that require lower extremity elevation; **or**
   d. Meets the criteria for and has a reclining back on the wheelchair.

G. **Residual Limb Support**

1. A residual limb support is covered when the beneficiary has had an amputation and the residual limb cannot be supported on a standard leg rest.

H. **Foot Rest/Shoe Holder**

1. Footrests, footplates, shoe holders, and straps are covered when the beneficiary requires lower extremity support due to muscular weakness, neuromuscular dysfunction or orthopedic deformity.

I. **Seat/Back**
   1. A **non-standard seat height** for a high-strength lightweight or ultra-lightweight wheelchair is covered when:
      a. The required seat height is at least two inches greater than or less than a standard option; **and**
      b. The beneficiary's body dimensions justify the need.
   2. **Non-standard seat frames** are covered when **all** the following criteria are met:
      a. The beneficiary's dimensions justify the need for wheelchair seat width, depth, or height changes; **and**
      b. The seat width, depth, or height changes are needed to maintain or improve the beneficiary's medical, physical, or functional level.
   3. A **solid seat insert** is covered when it is needed to provide a flat surface in a wheelchair with a sling seat so the beneficiary will be properly positioned.
   4. A **solid seat support base** is covered when it replaces a sling seat and is needed to properly position the beneficiary in the wheelchair. A solid seat support base requires approval.
   5. A **planar or contoured back** is covered when the beneficiary meets **all** the following criteria:
      a. Has a diagnosis that may result in deformities of the musculoskeletal system such that the normal body alignment could be significantly altered; **and**
      b. Spends more than two hours per day in the wheelchair.

J. **Growth Kit**
   1. Covered when the addition of this feature significantly increases the lifetime of the beneficiary's currently appropriate wheelchair. These items all require approval.

K. **Replacement Upholstery**
   1. Covered when the upholstery is damaged or worn beyond repair and replacing the upholstery will increase the lifetime of the wheelchair.

L. **Trunk/Extremity Alignment Support**
   1. Trunk/Extremity Alignment Supports, **including** lateral truck or hip supports, abductor or adductor pads, harnesses, straps, or positioning belts, are covered when:
      a. The beneficiary has weakness or abnormal muscle tone in the trunk, body, or extremity musculature resulting in significantly impaired function in those muscles; **or**
      b. The beneficiary is unable to actively maintain proper trunk or extremity positioning.

M. **Oversized Accessories**
   1. All oversized accessories require approval. For approval, all the following information must be included with the request:
      a. Beneficiary's height, weight, and body measurements; **and**
      b. The dimension of the requested equipment and the manufacturer's specified weight capacity for the equipment.

N. **Power Seating Systems**
   1. Power seating systems, **including** tilt, recline, and combination tilt and recline, require approval and are covered when the beneficiary meets **all** the following:

a. The beneficiary requires the tilt in space feature for proper positioning during daily activities, such as eating;
b. The beneficiary has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment;
c. The beneficiary is unable to actively change his or her upright seating position and is at risk for loss of skin integrity;
d. The beneficiary has respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature;
e. The beneficiary shall spend a minimum of six hours per day in the wheelchair; and
f. The beneficiary does not have a caregiver available to perform this function manually.

Power seat elevation is covered for beneficiary's ages 0 through 20 years only, when the beneficiary is not able to transfer from the wheelchair to bed or toilet without height adjustment or requires seat elevation to perform MRADLs. Approval is required.

O. **Electronics**
1. Electronic components for power wheelchairs are covered when they are medically necessary for the beneficiary to function in the power wheelchair that has been provided. Replacement electronics require approval and are covered when:
   a. the part replaced cannot be repaired
   b. the warranty has expired
   c. replacing the part significantly extends the life of the wheelchair, **and**
   d. the cost of replacing the part is less than the cost of a new comparable wheelchair.

P. **Wheels, Tires, Casters**
1. Propulsion tires, drive wheel tires, caster tires, tubes, valves, inserts, wheel locks, and replacement parts are covered when they are medically necessary for the beneficiary to function in the power wheelchair that has been provided.
2. Wheelchair replacement parts are covered when the part being replaced is no longer functional due to normal wear and tear and the approved wheelchair remains appropriate for the beneficiary's function.

Q. **Other Accessories**
1. Swing away retractable or removable hardware is covered when specialized mounting hardware is needed to improve the beneficiary's positioning or ability to use a joystick.
2. A ventilator tray is covered when the beneficiary is dependent on mechanical ventilator support.
3. Wheelchair trays are covered when the beneficiary's performance of daily function such as eating or fine motor activities requires this feature.
4. Hand rims are covered when the beneficiary is unable to propel independently and functionally without special hand rims and is able to propel with special hand rims.
5. Anti-rollback devices, gear reduction drive wheels, wheel braking systems and other accessories are covered when they allow the beneficiary to be mobile safely and independently in an approved wheelchair. A gear reduction drive wheel, wheel braking system, and lock require approval.
6. Motor and gear box replacements require approval and are covered when:
   a. the part replaced cannot be repaired;
   b. the warranty has expired;

c. replacing the part significantly extends the life of the wheelchair; **and**
d. the cost of replacing the part is less than the cost of a new comparable wheelchair.

VIII. It is the policy of WellCare of North Carolina® that **Activity/Positioning Chairs** meet medical necessity as follows:

A. Activity Chairs and accessories are covered for a beneficiary who has mild to moderate physical disabilities and needs positioning support to sit and perform activities.
B. An Activity Chair is considered medically necessary when a beneficiary meets **any** one of the following criteria:
   1. Cannot safely sit in a regular chair, commercially available high chair, or other conventional seating option;
   2. Needs additional support and stability for fine motor activities;
   3. Has decreased trunk strength and motor control;
   4. Must use arms to maintain sitting balance;
   5. Requires external support to maintain upright position and good body alignment;
   6. Has no functional protective or righting reaction; **or**
   7. Must be in an upright supported position for safe and effective feeding and without this chair would have to be held by the caregiver for feeding.
C. All **accessories** must be medically justified.
   1. A tilt/recline option is covered when the beneficiary:
      a. cannot maintain head control in the upright position;
      b. requires pressure relief;
      c. requires a tilted position to compensate for tonal changes; **or**
      d. must be tilted for proper digestion and to avoid reflux.
   2. A mobile base is covered when it is medically necessary to move the beneficiary to different parts of the environment with the rest of the family for safety or for medically necessary activities.
   3. A Hi Lo feature is covered when height adjustments are needed for medically necessary activities or to allow the beneficiary to get into or out of the chair independently.
D. **Hi Lo Positioning Activity Chairs**
   1. Hi Lo Positioning Chairs and accessories are covered for a beneficiary who has more severe physical disabilities and needs optimum positioning support. A Hi Lo Positioning Chair is considered medically necessary when a beneficiary meets **any one** of the following criteria:
      a. Has non-functional head or trunk control requiring customized postural support to maintain a sitting position;
      b. Cannot sit unsupported due to poor static and dynamic sitting balance;
      c. Requires maximum support for upright positioning;
      d. Cannot interact with the environment without this level of support; **or**
      e. Requires varying sitting heights to participate in medically necessary activities.
E. **Hi Lo Indoor Base/Frame**
   1. A Hi Lo Indoor Base is covered for beneficiary who has a wheelchair seating system that can be transferred from a mobility base to an indoor base and is used as an activity/positioning chair. A Hi Lo Indoor Base is considered medically necessary when a beneficiary meets **any one** of the following criteria:

a. A variety of heights are needed for the beneficiary to perform medically necessary activities; **or**
b. At the low height, the beneficiary is able to get into and out of the chair independently.

F. A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for approval of all Activity/Positioning Chairs and Frames. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

IX. It is the policy of WellCare of North Carolina® that **Patient Lift, Hydraulic or Mechanical** meet medical necessity as follows:

A. Hydraulic lifts are covered when the following criteria are met:
1. The beneficiary's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in the beneficiary's condition; **and**
2. The beneficiary or family is not able to transfer the beneficiary safely. Approval is required for a hydraulic or mechanical lift.

Note: Powered lifts are not covered as they are considered to be for caregiver convenience and not medically necessary.

X. It is the policy of WellCare of North Carolina® that **Segmental and Non-Segmental Pneumatic Compressors and Appliances** meet medical necessity as follows:

A. All pneumatic compressors and appliances require approval. A pneumatic compression device is covered only for the treatment of refractory lymphedema involving one or more limbs. This condition is a relatively uncommon medical problem. Causes of lymphedema include:
1. Radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy);
2. Post-radiation fibrosis;
3. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction;
4. Scarring of lymphatic channel;
5. Onset of puberty (specifically Milroy's Disease); **and**
6. Congenital anomalies.

B. Pneumatic compression devices are only covered as a treatment of last resort. Other less intensive treatment must have been tried first and found to be inadequate. Such treatments would include:
1. leg or arm elevation **and**
2. custom fabricated pressure stockings or sleeves.

C. Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight. This oversight must include:
1. physician evaluation of the beneficiary's condition to determine medical necessity of the device;
2. suitable instruction in the operation of the machine;
3. a treatment plan defining the pressure to be used and the frequency and duration of use; **and**
4. ongoing monitoring of use and response to treatment.

D. When the cause of the lymphedema is scarring of the lymphatic channels (generalized, refractory edema from venous insufficiency which is complicated by recurrent cellulitis), a pneumatic compression device may be covered only if **all** the following criteria have been met:
   1. There is significant ulceration of the lower extremity(ies);
   2. The beneficiary has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent; **and**
   3. The ulcer(s) have failed to heal after six months of continuous treatment.

XI. It is the policy of WellCare of North Carolina® that **Transcutaneous Electrical Nerve Stimulation Devices** meet medical necessity as follows:

A. Approval is required for a TENS unit. For initial and renewal approval, attach documentation that the main application is to control or suppress chronic painful states that are not amenable to control through elimination of the cause. The following information is also required:
   1. The specific diagnosis related to the need for the unit;
   2. Date of onset and duration of pain;
   3. Specific area(s) of pain;
   4. Prognosis; **and**
   5. The physician, physician assistant, or nurse practitioner's statement that other appropriate treatments to ameliorate the pain have been tried without success. The specific treatments, including pain medications, must be included in the statement.
   6. A pain scale and body map that shows the severity of the pain and the specific locations of the pain.

XII. It is the policy of WellCare of North Carolina® that **Osteogenesis Stimulators** meet medical necessity as follows:

A. All osteogenesis stimulators require approval.
B. An electrical non-invasive osteogenesis stimulator for **non-spinal** applications is covered for the following conditions:
   1. Non-union of a long bone (clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal) fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator;
      a. Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician, physician assistant, or nurse practitioner stating that there has been no evidence of fracture healing between the two sets of radiographs. An osteogenesis stimulator for a non-healed long bone fracture of less than six (6) months duration or a lack of fusion of less than 12 months duration is not medically necessary and claims will be denied.
   2. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery; **and**
   3. Congenital pseudarthrosis.

C. A non-invasive electrical osteogenesis stimulator for **spinal** applications is covered when medical necessity is documented and the beneficiary has **one** of the following:
   1. A failed spinal fusion where a minimum of nine months has elapsed since the last surgery;
   2. A multilevel spinal fusion surgery. A multilevel spinal fusion is one that involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); **or**
   3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

D. A **non-invasive, low-intensity** ultrasonic osteogenesis stimulator is covered if all the following criteria are met:
   1. Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;
   2. Fracture is not of the skull or vertebrae; **and**
   3. Fracture is not tumor related.

XIII. It is the policy of WellCare of North Carolina® that **Continuous Passive Motion Exercise Device for Use on Knee Only** meet medical necessity as follows:

A. A continuous passive motion exercise device is covered for beneficiaries who have received a total knee replacement.
B. To qualify for coverage, use of the device must commence within two days following surgery.
C. Coverage is limited to the three-week period following surgery.
D. The beneficiary's status will be monitored by the physician while this equipment is provided.

XIV. It is the policy of WellCare of North Carolina® that **Canes, Crutches, Walkers, Gait Trainers, and Accessories** meet medical necessity as follows:

A. **Canes and crutches** are covered when **all** the following criteria are met:
   1. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs); The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing. A mobility limitation is one that:
      a. prevents the beneficiary from accomplishing the MRADL entirely;
      b. places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; **or**
      c. prevents the beneficiary from completing the MRADL within a reasonable time frame.
   2. The beneficiary is able to safely use the cane or crutch; **and**
   3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

B. A **crutch substitute, lower leg platform**, requires approval and is covered if the beneficiary meets the above criteria and is not able to safely use crutches or a walker.
C. **Heavy Duty Canes and Crutches**

1. Heavy duty canes and crutches are covered for beneficiaries who weigh more than 250 pounds. The beneficiary's height, weight, and body measurements must be provided as well as the dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment.

D. **Walkers**
   1. A standard walker and related accessories are covered if **all** the following criteria are met:
      a. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs. A mobility limitation is **one** that:
         i. prevents the beneficiary from accomplishing the MRADL entirely, **or**
         ii. places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL; **or**
         iii. prevents the beneficiary from completing the MRADL within a reasonable time frame.
      b. The beneficiary is able to safely use the walker.
      c. The functional mobility deficit can be sufficiently resolved with use of a walker.
   2. **Glides/skis** for use with a walker are covered when the beneficiary requires them to mobilize an approved walker.
   3. To substantiate medical necessity for **heavy duty** walkers, the beneficiary's height, weight, and body measurements must be provided as well as the manufacturer's specified weight capacity for the equipment.

E. **Gait Trainers**
   1. A gait trainer is a device similar to a walker and consists of a wide-based steel frame with four casters or wheels. It provides considerable postural support for beneficiaries who have severe motor and balance dysfunction and who require moderate to maximum support for ambulation. Additional components, called positioners or stabilizers, are added to offer additional support and control.
   2. A gait trainer with accessories requires approval and may be covered for **beneficiaries aged 0 through 20**, if an evaluation by a physical or occupational therapist documents that the following criteria are met:
      a. The beneficiary needs moderate to maximal support for walking due to impaired balance reactions or pelvic or trunk instability or has a Gross Motor Function Classification System (GMFCS) score of 3 or greater.
      b. The beneficiary is able to initiate movement without caregiver assistance, and there is a purposeful need for the movement. The physical or occupational therapist shall document medical necessity for all components included with the gait trainer. The physical or occupational therapist completing the evaluation cannot be employed by the medical equipment provider.

XV. It is the policy of WellCare of North Carolina® that **Miscellaneous Durable Medical Equipment and Medical Supplies** meet medical necessity as follows:

A. **Cervical traction** equipment is covered if it is ordered by a physician for treatment of a specified orthopedic diagnosis.

B. Transfer boards or other **transfer devices** are covered when a beneficiary requires the device to complete transition from one position to another, (such as from bed to wheelchair or wheelchair to bathtub seat).

C. A **paraffin bath** is covered when a beneficiary has a documented diagnosis for which paraffin treatment is deemed beneficial by the beneficiary's physician.
D. An **over tub portable whirlpool bath** unit is covered when a beneficiary has a documented diagnosis for which whirlpool treatment is deemed beneficial by the beneficiary's physician.

XVI. It is the policy of WellCare of North Carolina® that **Augmentative and Alternative Communication Devices** meet medical necessity as follows:

A. Augmentative and alternative communication (AAC) devices help beneficiaries with severe communication impairments to meet their functional communication needs. AAC devices, software, and related accessories are covered when **all** the following conditions are met:
   1. The device is determined to be medically necessary;
   2. The device is a dedicated communication device;
      a. a dedicated device is defined as a device used only for communication purposes.
   3. It is used solely by the beneficiary; **and**
   4. The beneficiary has a long-term severe communication impairment.

B. The **ACC** device may be **one** of the following:
   1. A manual device that uses orthographic or picture symbols;
   2. A device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer); **or**
   3. A device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods.

   Note: A laptop computer, desktop computer, personal digital assistant, or other device that has not been modified to run AAC software and is not a device used only for communication purposes (that is, a dedicated device) is not covered. Laptop computers, personal computers, and personal digital assistants used for purposes other than communication are not primarily medical in nature and do not meet the definition of medical equipment.

   AAC software is covered when a beneficiary has a laptop computer, desktop computer, or personal digital device in which software can be added to adapt the device for communication purposes.

C. Speech-generating devices that produce synthesized speech, software, accessories, and AAC repairs require approval. To document medical necessity for approval, the following documentation must be submitted:
   1. A physician's report with a description of the beneficiary's current medical status and history
   2. A physician's order for the AAC device, including an itemization of the components (switches, special mounting devices, etc.) required by the beneficiary
   3. An AAC device evaluation performed by a licensed speech–language pathologist who fulfills **either** requirements a and c, **or** requirements b and c, below:
      a. Has a valid license issued by the North Carolina Speech and Language Pathologists and Audiologists Board of Examiners, **and** has a Certificate of Clinical Competence (CCC) from the American Speech–Language– Hearing Association (ASHA);
      b. Has **either** completed the equivalent educational requirements and work experience necessary for the CCC, **or** has completed the academic program and is acquiring supervised work experience to qualify for the CCC;

c. Has the education and experience in augmentative communication necessary to assess an individual and prescribe an AAC aid, system, or device that will maximize that individual's effective and functional communication.

4. The AAC device evaluation must include **all** the following information:
   a. The language skills, oral and motor speech status, and type and severity of current communication impairment(s) that affect the beneficiary's abilities to communicate with and without the AAC device;
   b. A detailed description of the therapeutic history in the areas of speech language pathology, occupational therapy, and physical therapy, including the nature, frequency, and duration of treatment and the specific speech language therapy approaches that have been tried in relation to the need for and use of an AAC device;
   c. A detailed description of related impairments, including audiovisual, perceptual, cognitive level, and memory deficits, that would limit the beneficiary's ability to use a device, or that would require the use of a particular AAC device;
   d. A detailed description of each communication device or method of communication tried by the beneficiary in the past and information on the effectiveness of each;
   e. Specific information about the requested device, including the manufacturer's name, catalog number, product description, and list of accessories requested; justification for and use to be made of the device and accessories; and documentation of the manufacturer's price quote;
   f. An explanation of the medical necessity of the AAC device, including how the device will be used and a statement that the device will be required for 12 months or longer;
   g. Demonstration that the beneficiary possesses a treatment plan that includes a training schedule for the selected device (technical assistance from the AAC vendor must include training on the use of the AAC device); **and**
   h. A statement that the speech-language pathologist performing the AAC device evaluation is neither an employee of nor has a financial relationship with the vendor of the AAC device.

   Note: Medical necessity must be supported even if prior approval is not required. Therefore, the above-listed requirements also apply to devices that do not require prior approval. In this instance, the information necessary to establish medical necessity must be kept in the beneficiary's confidential file by the speech– language pathologist responsible for ordering the device.

D. **Cost**, **Accessories**, **and Repairs**
   1. Technical assistance from a qualified augmentative communication technology professional also includes training on use of the AAC equipment and is included in the total purchase price for the AAC device. Technical assistance may not duplicate evaluation and services provided by licensed speech, occupational, or physical therapists.
   2. Requests for repairs must be approved in advance.
   3. The lifetime expectancy for all AAC devices is three years. An AAC device may be modified or replaced in **one** of the following situations:
      a. The beneficiary's medical, cognitive, or physical status changes in such a way as to significantly alter the effectiveness of the device.

b. The AAC device is no longer functional and cannot be repaired.
c. The manufacturer's warranty or other applicable warranty has expired and repairs to the AAC device are no longer cost effective. An identical or comparable component(s) will be provided if there is documentation from a licensed speech-language pathologist that the AAC device is still effective and appropriate for the beneficiary's needs.
d. The device is under manufacturer's warranty, but the repair is not covered by the warranty. Submit documentation from the manufacturer explaining the reason that the repair is not covered.
e. The AAC device has been damaged or stolen. A copy of the police or fire report must be submitted, if appropriate, and detail the measures to be taken to prevent reoccurrence.

Note: All documentation of the history of service, maintenance, and repair of the device must accompany such a request. The plan will not purchase an extended manufacturer's warranty for any AAC device.

XVII. It is the policy of WellCare of North Carolina® that **Standers** meet medical necessity as follows:

A. A **sit-to-stand** stander is medical equipment that transitions a beneficiary who cannot stand on his or her own from a sitting to an upright standing position, with the ability to stop at any point in between and be supported during incremental weight bearing. This stander may include additional accessories for support. A **multi-position** stander is medical equipment that transitions a beneficiary from the horizontal prone or supine position to an upright standing position. It is angle adjustable to provide graduated weight bearing and pressure. It is designed for either prone or supine standing. This stander may include additional accessories for support.
B. A **stander and stander accessories** require approval and are covered for a beneficiary, age **0 through 20 years**, if an evaluation by a physical or occupational therapist document that the following criteria are met:
   1. The beneficiary requires moderate to maximal support for standing in the environment;
   2. The beneficiary is unable to stand or ambulate due to long term medical conditions and ambulation will most likely not occur;
   3. Effective weight bearing cannot be achieved by any other means;
   4. The stander has been tried and used safely by the beneficiary;
   5. The beneficiary's environment can accommodate the stander;
   6. The beneficiary has demonstrated motivation to stand and the beneficiary's caregiver is willing and able to carry out a prescribed standing program.

   Note: The physical or occupational therapist completing the evaluation cannot be employed by or have a financial relationship with the medical equipment provider.
   7. The provider shall list all accessories included with the stander and document medical necessity for all accessories **except** the following:
      a. Knee supports
      b. Hip supports
      c. Chest support
      d. Footplate or sandals
      e. Lateral supports

f. Straps
g. Tray

Note: A mobile option, power lift option, or glider option are not covered accessories.

XVIII. It is the policy of WellCare of North Carolina® that **Bath and Toilet Aids** meet medical necessity as follows:

A. **Bath/Shower Chair or Bench**
1. A **Bath/Shower** Chair is considered medically necessary when a beneficiary cannot stand for bathing.
2. A **Tub Transfer Bench** is considered medically necessary when a beneficiary cannot safely get into or out of a bath tub. A heavy duty transfer bench is allowed for a beneficiary who weighs 250 pounds or more.
3. A **raised toilet seat** is considered medically necessary when a beneficiary cannot get up from or down to a standard commode.
4. A **commode chair** is considered medically necessary for a beneficiary who is physically incapable of using a standard toilet or who cannot access the bathroom. A commode chair, extra wide or heavy duty is covered for a beneficiary who weighs 250 pounds or more.

B. **Pediatric: Bath Chairs, Shower Chairs and Bath Lifts**
1. The **pediatric bath chair** is considered medically necessary when a beneficiary meets **any** one of the following criteria:
   a. Cannot maintain a sitting position independently;
   b. Needs to be positioned in a reclining or tilted position for bathing;
   c. Has poor or limited head control in supported sitting;
   d. Cannot be safely lifted out of a bath tub due to size or weight; **or**
   e. Requires proper positioning and additional support for safe bathing.
   f. The following safety equipment is used in conjunction with a pediatric bath chair. This equipment includes the following:
      i. bath chair lateral supports, chest or pelvic straps, or wedge and pommel cushions are medically necessary when a beneficiary requires additional support to maintain the head or trunk in proper alignment or to maintain the beneficiary safely on the bath chair while bathing.
      ii. a tub stand or shower stand is medically necessary when the beneficiary cannot be safely transferred out of the tub from the pediatric bath chair and additional height is needed for safety or when the bath chair is to be used in a shower.
      iii. a shower trolley is medically necessary when a beneficiary cannot be safely lifted and placed onto the bath chair and must be transferred from bed to bath chair and transported into the shower on the shower trolley.
      iv. a hand-held shower is medically necessary when the shower water must be redirected or diverted for safe and effective bathing.
2. **Bath Support**
   a. A bath support is considered medically necessary when a beneficiary meets **any** one of the following criteria:
   b. Requires minimal to moderate assistance to maintain an upright seated position;
   c. Exhibits extensor thrusting; **or**
   d. Has abnormal muscle tone.

3. **Bath Lift**
   a. A bath lift is considered medically necessary when a beneficiary meets any **one** of the following criteria:
   b. Needs moderate to maximal assistance to get down into the tub and to get back up and cannot be safely lifted into and out of the tub when wet by caregivers due to size or medical condition;
   c. Has a balance deficit or poor head and trunk control and cannot safely sit on a tub bench or other less supportive equipment; **or**
   d. Is independent with bathing and positioning and is able to manage the bath lift controls but cannot transfer into and out of the tub safely.
4. **Shower/Commode Chair**
   a. A shower/commode chair is considered medically necessary when a beneficiary meets any **one** of the following criteria:
      i. is not able to stand for bathing in the shower;
      ii. cannot be safely assisted into or out of a bath tub for bathing;
      iii. does not have adequate balance or trunk support to sit on a tub bench for bathing; **or**
      iv. does not have access to a bathtub and cannot stand for bathing in a shower.

      All accessories for this chair require medical justification which must be included in the medical information provided.
5. **Tilt/Recline Shower/ Commode Chair**
   a. A tilt / recline shower /commode chair is considered medically necessary when a beneficiary meets any **one** of the following criteria:
      i. has extensive weakness, contractures, or abnormal tone requiring full body support;
      ii. requires total assistance for transfers and bathing;
      iii. cannot sit upright and must be tilted or reclined for safe positioning while bathing;
      iv. has a medical need that requires the tilted or reclined position when upright; **or**
      v. requires pressure relief at all times when sitting.

      All accessories for this chair require medical justification and must be included in the medical information provided.
6. **Pediatric Bath Shower Transfer System**
   a. A bath shower transfer system is considered medically necessary when a beneficiary meets any **one** of the following criteria:
      i. requires maximal assistance to sit;
      ii. has extensive weakness, contractures, or abnormal tone requiring full body support;
      iii. requires total assistance for transfers and bathing; **or**
      iv. must use a bathtub for bathing.
7. A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for approval of all pediatric bath chairs, shower/commode chairs, bath lifts, and bath transfer systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider. For approval, the medical

equipment provider shall submit a completed medical necessity form and supporting documentation from the physical or occupational therapist that:

a. Demonstrates that the bathing device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the beneficiary's medical condition.
b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the beneficiary.

C. **Pediatric Toilet Supports and Systems**

1. Are covered for beneficiaries ages **0 through 20 years**, when they are medically necessary and:
   a. the beneficiary shall be toilet trained; **or**
   b. capable of being toilet trained within six months and able to participate in a toileting program.
2. **Toilet Seat Reducer Ring**
   a. Considered medically necessary when a beneficiary, age **0 through 20 years**, is too small to sit safely on a regular commode because the opening is too large but can safely sit on the commode for toileting with the reducer ring added.
3. **Lo-Back Toilet Support**
   a. Considered medically necessary when a beneficiary, age **0 through 20 years**, meets **any** one of the following criteria:
      i. cannot maintain balance while sitting on a commode and requires pelvic or trunk support to avoid loss of balance;
      ii. has trunk weakness or tonal abnormalities;
      iii. has poor protective reactions resulting in loss of balance and needs support for safety; **or**
      iv. is unable to sit on a regular toilet seat without assistance of a caregiver to maintain balance.
4. **Potty Trainer**
   a. Considered medically necessary when a beneficiary, age **0 through 20 years**, meets **any** one of the following criteria is met:
      i. toileting or toilet training needs to take place in locations other than a bathroom;
      ii. cannot be maintained in a stable position while sitting on a commode and requires additional support for beneficiary to feel secure; **or**
      iii. has deficits in balance, coordination, or function.

      All accessories must be medically necessary to safely support the beneficiary while toileting.
5. **Toileting System**
   a. Considered medically necessary when a beneficiary, **age 0 through 20 years**, meets **any** one of the following criteria:
      i. cannot sit on a commode without the complete support of a caregiver;
      ii. has significant deficits in balance, coordination, or abnormalities in tone;
      iii. has poor head or trunk control; **or**
      iv. will be independent in toileting with the use of this system.
6. All accessories must be medically necessary to safely support the beneficiary while toileting.

7. A letter of medical necessity from a physical or occupational therapist involved in the care of the beneficiary is required for approval of all Pediatric Toilet Supports and Systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.
8. For approval, the medical equipment provider shall submit all supporting documentation from the physical or occupational therapist that:
    a. Demonstrates that the toileting device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the beneficiary's medical condition.
    b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the beneficiary.

XIX. It is the policy of WellCare of North Carolina® that **Provision of DME and Medical Supplies on the Date of Discharge from Specified Facilities** meet medical necessity as follows:

A. Items identified on HCPCS Code list in Attachment B as included in https://files.nc.gov/ncdma/documents/files/5A-1_6.pdf must be provided to a beneficiary, discharged home on the date of Discharge from a skilled nursing facility, short term physical disability rehabilitation center or hospital only.
B. Delivery of DMES on the date of discharge from a skilled nursing facility, short term physical disability rehabilitation center or hospital shall be consistent applicable policies
C. For items that require PA, the DMES provider shall submit a prescriber's order and an admission history and physical note and any supporting documentation via the appropriate means.
D. For items that do not require PA, the DMES provider shall keep the prescriber's order, a history and physical note, and any supporting documentation on file.

XX. It is the policy of WellCare of North Carolina® that the **amount of service** is limited to that which is medically necessary as determined by NC Medicaid's clinical coverage policies. Refer to https://files.nc.gov/ncdma/documents/files/5A-1_6.pdf Attachment A, Section C: Procedure Code(s), for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Medical Supplies.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
No applicable codes.	

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E0250	Hospital bed, fixed height, with any type side rails, with mattress	5 years
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	5 years
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	5 years
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	5 years
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 lbs., but less than or equal to 600 lbs., with any type of side rails, with mattress	5 years
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 lbs., with any type of side rails, with mattress	5 years
E0271	Mattress, innerspring	3 years
E0272	Mattress, foam rubber	3 years
E0305	Bed side rails, half length	3 years
E0310	Bed side rails, full length	3 years
E0840	Traction frame, attached to headboard, cervical traction	3 years
E0890	Traction frame, attached to footboard, pelvic traction	3 years
E0910	Trapeze bars, A/K/A patient helper, attached to bed, with grab bar	3 years
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, complete with grab bar	3 years
E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar	3 years
E0940	Trapeze bar, free standing, complete with grab bar	3 years
E0276	Bed pan, fracture, metal or plastic	3 years
E0280	Bed cradle, any type	3 years
E0325	Urinal; male, jug-type, any material	6 per year
E0326	Urinal; female, jug-type, any material	6 per year
E0300	Pediatric crib, hospital grade, fully enclosed, With or without top enclosure	0-20 years only: 5 years
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	0-20 years only: 5 years
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress	0-20 years only: 5 years
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress	0-20 years only: 5 years
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient	2 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	3 years
E0182	Pump for alternating pressure pad, for replacement only	3 years
E0184	Dry pressure mattress	3 years
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	3 years
E0186	Air pressure mattress	3 years
E0187	Water pressure mattress	3 years
E0196	Gel pressure mattress	3 years
E0197	Air pressure pad for mattress, standard mattress length and width	3 years
E0198	Water pressure pad for mattress, standard mattress length and width	3 years
E0199	Dry pressure pad for mattress, standard mattress length and width	3 years
E0193	Powered air flotation bed (low air loss therapy)	5 years
E0277	Powered pressure-reducing air mattress	5 years
E0371	Non powered advanced pressure reducing overlay for mattress, standard mattress length and width	5 years
E0372	Powered air overlay for mattress, standard mattress length and width	5 years
E0373	Non powered advanced pressure reducing mattress	5 years
E0194	Air fluidized bed	N/A (Rental only)
K0001	Standard wheelchair	3 years
K0002	Standard hemi (low seat) wheelchair	3 years
K0003	Lightweight wheelchair	3 years
K0004	High strength, lightweight wheelchair	3 years
K0005	Ultra-lightweight wheelchair	3 years
K0006	Heavy duty wheelchair	3 years
K0007	Extra heavy duty wheelchair	3 years
E1161	Manual adult size wheelchair, includes tilt in space	3 years
E1031	Roll-about chair, any and all types with castors 5” or greater	2 years
E1037	Transport chair, pediatric size	4 years
E1038	Transport chair, adult size, patient weight capacity up to and including 300 pounds	4 years
E1039	Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds	4 years
E1229	Wheelchair, pediatric size, not otherwise specified	3 years
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	3 years
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	3 years
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	3 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	3 years
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	3 years
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	3 years
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system	3 years
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system	3 years
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	4 years
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds	4 years
E1239	Power wheelchair, pediatric size, not otherwise specified	4 years
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	4 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds	4 years
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	4 years
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	4 years
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	4 years
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0825	Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	4 years
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0827	Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	4 years
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0829	Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight 601 pounds or more	4 years
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
K0838	Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	4 years
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0843	Power wheelchair, group 2 heavy duty, multiple power options, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0851	Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	4 years
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0853	Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	4 years
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	4 years
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	4 years
K0859	Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	4 years
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	4 years
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	4 years
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	4 years
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	4 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2358	Power wheelchair accessory, group 34, non-sealed lead acid battery, each	2 per year
E2359	Power wheelchair accessory, group 34, sealed lead acid battery each, e.g. gel-cell, absorbed glass mat	2 per year
E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each	2 per year
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glassmat)	2 per year
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	2 per year
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	2 per year
E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery, each	2 per year
E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	2 per year
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	1 year ages 0-20; 2 years 21 and over
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	1 year ages 0-20; 2 years 21 and over
E2371	Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each	2 per year
E2372	Power wheelchair accessory, group 27 non-sealed lead acid battery, each	2 per year
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	2 per year
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	2 per year age 0-20; 2 per 3 years 21 and over
E2209	Accessory arm trough, with or without hand support, each	2 per year age 0-20; 2 per 3 years 21 and over
K0015	Detachable, non-adjustable height armrest, each	2 per year age 0-20; 2 per 3 years 21 and over
K0017	Detachable, adjustable height armrest, base replacement only, each	2 per year age 0-20; 2 per 3 years 21 and over
K0018	Detachable, adjustable height armrest, upper portion, replacement only, each	2 per year age 0-20; 2 per 3 years 21 and over
K0019	Arm pad, replacement only, each	2 per 2 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
K0020	Fixed, adjustable height armrest, pair	1 per year 0-20 1 per 3 years 21-115
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth	2 years ages 0-20; 3 years 21 and over
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth	2 years ages 0-20; 3 years 21 and over
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	3 years
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	3 years
E2609	Custom fabricated wheelchair seat cushion, any size	3 years
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	3 years
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	3 years
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	3 years
E2616	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	3 years
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	3 years
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	2 years ages 0-20; 3 years 21 and over
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	2 years ages 0-20; 3 years 21 and over
E2622	Skin protection wheelchair seat cushion, adjustable width less than 22 inches, any depth	3 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	3 years
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	3 years
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	3 years
E2626	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	1 every 6 mo. age 0-20 1 per 3 years 21-115
E2627	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	1 every 6 mo. ages 0-20 1 per 3 years 21-115
E2628	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	1 every 6 mo. age 0-20 1 per 3 years 21-115
E2629	Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	1 every 6 mo. age 0-20 1 per 3 years 21-115
E2630	Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	1 every 6 mo age 0-20 1 per 3 years 21-115
E2631	Wheelchair accessory, addition to mobile arm support, elevating proximal arm	1 every 6 mo age 0-20 1 per 3 years 21-115
E2632	Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	1 every 6 mo age 0-20 1 per 3 years 21-115
E2633	Wheelchair accessory, addition to mobile arm support, supinator	1 every 6 mo age 0-20 1 per 3 years 21-115
E0966	Manual wheelchair accessory, headrest extension, each	1 year ages 0-20; 2 years 21 and over
W4130	Contoured or 3-piece head/neck supports with hardware	1 year ages 0-20; 3 years 21 and over
W4131	Basic head/neck support with hardware	1 year ages 0-20; 3 years 21 and over
W4132	Contoured or 3-piece head/neck support with multi-adjustable hardware	1 year ages 0-20; 3 years 21 and over
W4133	Basic head/neck support with multi-adjustable hardware	1 year ages 0-20; 3 years 21 and over
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	1 year ages 0-20; 3 years 21 and over

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	1 year ages 0-20; 3 years 21 and over
E1020	Residual limb support system for wheelchair, any type	1 year ages 0-20; 3 years 21 and over
K0046	Elevating leg rest, lower extension tube, replacement only, each	1 year ages 0-20; 3 years 21 and over
K0047	Elevating leg rest, upper hanger bracket, replacement only, each	1 year ages 0-20; 3 years 21 and over
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)	1 year ages 0-20; 3 years 21 and over
E0951	Heel loop/holder, any type, with or without ankle strap, each	1 year ages 0-20; 2 years 21 and over
E0952	Toe loop/holder, any type, each	2 years
E0995	Wheelchair accessory, calf rest/pad, replacement only, each	2 years
K0037	High mount flip-up footrest, each	1 year ages 0-20; 3 years 21 and over
K0038	Leg strap, each	1 year ages 0-20; 2 years 21 and over
K0039	Leg strap, H style, each	1 year ages 0-20; 2 years 21 and over
K0040	Adjustable angle footplate, each	1 year ages 0-20; 3 years 21 and over
K0041	Large size footplate, each	3 years
K0042	Standard size footplate, replacement only, each	3 years
K0043	Footrest, lower extension tube, replacement only, each	3 years
K0044	Footrest, upper hanger bracket, replacement only, each	3 years
K0045	Footrest, complete assembly, replacement only, each	1 year ages 0-20; 3 years 21 and over
K0050	Ratchet assembly, replacement only	1 year ages 0-20; 3 years 21 and over
K0051	Cam release assembly, footrest or leg rest, replacement only, each	1 year ages 0-20; 3 years 21 and over
K0052	Swing-away, detachable footrests, replacement only, each	1 year ages 0-20; 3 years 21-115
K0053	Elevating footrests, articulating (telescoping), each	1 year ages 0-20; 3 years 21 and over
W4143	Shoe holders with hardware, pair	1 year ages 0-20; 2 years age 21 and over
W4144	Foot/leg rest cradle, each	1 year ages 0-20; 2 years ages 21 and over

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
K0056	Seat height less than 17" or equal to or greater than 21" for a high strength, lightweight or ultra-lightweight wheelchair	1 year ages 0-20; 3 years ages 21 and over
E0981	Wheelchair accessory, seat upholstery, replacement only, each	2 years
E0982	Wheelchair accessory, back upholstery, replacement only, each	2 years
E0992	Manual wheelchair accessory, solid seat insert	1 year ages 0-20; 3 years 21 and over
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	3 years
E2202	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches	3 years
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	3 years
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	3 years
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	2 year ages 0-20, 3 years 21 and over
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	0-20 years only; 2 years
E2295	Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	0-20 years only; 2 years
E2340	Power wheelchair accessory, non-standard seat frame width, 20-23 inches	4 years
E2341	Power wheelchair accessory, non-standard seat frame width, 24-27 inches	4 years
E2342	Power wheelchair accessory, non-standard seat frame depth, 20 or 21 inches	4 years
E2343	Power wheelchair accessory, non-standard seat frame depth, 22-25 inches	4 years
W4119	Wheelchair seat height, optional	3 years
W4152	Growth kit, each	1 year ages 0-20 2 years ages 21 and over
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	2 year ages 0-20, 3 years 21 and over

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each	2 year ages 0-20, 3 years 21 and over
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	2 year ages 0-20, 3 years 21 and over
E0978	Wheelchair accessory, positioning belts/safety belt/pelvic strap, each	1 year ages 0-20, 3 years 21 and over
E0980	Safety vest, wheelchair	3 years
W4139	Sub-ASIS bars with hardware, each	1 year ages 0-20, 3 years 21 and over
W4140	Abductor pads with hardware, pair	1 year ages 0-20, 3 years 21 and over
W4141	Knee blocks with hardware, pair	1 year ages 0-20, 3 years 21 and over
W4155	Adductor pads with hardware, pair	1 year ages 0-20, 3 years 21 and over
W4713	Oversized footplates for weights 301# and greater, pair	3 years
W4714	Swing away special construction footrests for weights 401# and greater, pair	3 years
W4715	Swing away reinforced leg rest elevating, for weights 301# to 400#, pair	3 years
W4716	Swing away special construction leg rest, elevation for weights 401# and greater, pair	3 years
W4717	Oversized calf pads, pair	2 years
W4718	Oversized solid seat	3 years
W4719	Oversized solid back	3 years
W4722	Oversized full support footboard	3 years
W4723	Oversized full support calf board	3 years
E1002	Wheelchair accessory, power seating system, tilt only	5 years
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	5 years
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	5 years
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	5 years
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	5 years
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	5 years
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	5 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2300	Wheelchair accessory, power seat elevation system, any type	0-20 years only; 3 years
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2312	Power wheelchair accessory, hand or chin control interface, mini proportional remote joystick, proportional, including fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2313	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	2 years ages 0-20; 4 years 21 and over
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, non-proportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	2 years
E2324	Power wheelchair accessory, chin cup for chin control interface	2 years
E2325	Power wheelchair accessory, sip and puff interface, non-proportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware	2 years ages 0-20; 4 years 21 and over
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	2 years
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional, including all related	2 years ages 0-20; 4 years 21 and over

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
	electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	2 years ages 0-20; 4 years 21 and over
E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2375	Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2376	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	2 years ages 0-20; 4 years 21 and over
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	2 years ages 0-20; 4 years 21 and over
E2378	Power wheelchair component, actuator, replacement only	2 years
E2205	Manual wheelchair accessory, hand rim without projections (includes ergonomic or contoured), any type, replacement only, each	3 years
E2206	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each	2 per 3 years
E2210	Wheelchair accessory, bearings, any type, replacement only, each	1 year
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	1 year
E2212	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	1 year
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	1 year
E2214	Manual wheelchair accessory, pneumatic caster tire, any size, each	1 year
E2215	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	1 year
E2216	Manual wheelchair accessory, foam filled propulsion tire, any size, each	2 years
E2217	Manual wheelchair accessory, foam filled caster tire, any size, each	1 year
E2218	Manual wheelchair accessory, foam propulsion tire, any size, each	1 year
E2219	Manual wheelchair accessory, foam caster tire, any size, each	1 year
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each	1 year
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	1 year
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	1 year

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2224	Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each	1 year
E2225	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1 year
E2226	Manual wheelchair accessory, caster fork, any size, replacement only, each	1 year
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each	1 year
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	1 year
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	1 year
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	1 year
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	1 year
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	1 year
E2386	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	1 year
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	1 year
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	1 year
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each	1 year
E2390	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each	1 year
E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	1 year
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	1 year
E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	1 year
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	1 year
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each	1 year
K0065	Spoke protectors, each	0-20 years only; 2 years
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each	1 year ages 0-20

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
		3 years ages 21 and over
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each	1 year ages 0-20 3 years ages 21 and over
K0071	Front caster assembly, complete, with pneumatic tire, replacement only, each	1 year ages 0-20 3 years ages 21 and over
K0072	Front caster assembly, complete, with semi-pneumatic tire, replacement only, each	1 year ages 0-20 3 years ages 21 and over
K0073	Caster pin lock, each	1 year ages 0-20 3 years ages 21 and over
K0077	Front caster assembly, complete, with solid tire, replacement only, each	1 year ages 0-20 3 years ages 21 and over
E0950	Wheelchair accessory, tray, each	1 year ages 0-20 3 years 21 and over
E0958	Manual wheelchair accessory, one-arm drive attachment, each	1 year ages 0-20 3 years 21 and over
E0959	Manual wheelchair accessory, adapter for amputee, each	1 year ages 0-20 3 years 21 and over
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each	1 year ages 0-20 3 years 21 and over
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each	1 year ages 0-20 3 years 21 and over
E0971	Manual wheelchair accessory, anti-tipping device, each	2 years
E0974	Manual wheelchair accessory, anti-rollback device, each	1 year ages 0-20 3 years 21 and over
E1028	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	2 years
E1029	Wheelchair accessory, ventilator tray, fixed	3 years
E1030	Wheelchair accessory, ventilator tray, gimbaled	3 years
E2207	Manual wheelchair accessory, crutch and cane holder, each	1 year ages 0-20 3 years 21 and over
E2208	Manual wheelchair accessory, cylinder tank carrier, each	1 year ages 0-20 3 years 21 and over
E2227	Manual wheelchair accessory, gear reduction drive wheel, each	1 year
E2368	Power wheelchair component, drive wheel motor, replacement only	2 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2369	Power wheelchair component, drive wheel gear box, replacement only	2 years
E2370	Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only	2 years
K0105	IV hanger, each	1 year ages 0-20 3 years 21 and over
W4005	Unlisted replacement or repair parts	N/A
W4145	Manual tilt-in-space option, each	1 year ages 0-20 3 years 21 and over
W4150	Multi-adjustable tray, each	1 year ages 0-20 2 years 21 and over
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)	3 years
E0621	Sling or seat, patient lift, canvas or nylon	2 years
E0650	Pneumatic compressor, non-segmental home model	2 years
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	3 years
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	3 years
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	2 years
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	2 years
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	2 years
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	2 years
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	2 years
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	2 years
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	2 years
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	2 years
E0671	Segmental gradient pressure pneumatic appliance, full leg	2 years
E0672	Segmental gradient pressure pneumatic appliance, full arm	2 years
E0673	Segmental gradient pressure pneumatic appliance, half leg	2 years
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation	2 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	2 years
A4595	Electrical stimulator supplies, 2 lead, per month (e.g., TENS, NMES)	2 per month
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal application	N/A
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications	N/A
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	N/A
E0935	Continuous passive motion exercise device for use on knee only	N/A
A4635	Underarm pad, crutch, replacement, each	6 months ages 0-20; 1 year 21 and over
A4636	Replacement, handgrip, cane, crutch, or walker, each	6 months ages 0-20; 1 year 21 and over
A4637	Replacement, tip, cane, crutch, walker, each	6 months ages 0-20; 1 year 21 and over
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip	2 years ages 0-20; 3 years 21 and over
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	2 years ages 0-20; 3 years 21 and over
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0111	Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0113	Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip	2 years ages 0-20; 3 years 21 and over
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	2 years ages 0-20; 3 years 21 and over
E0118	Crutch substitute, lower leg platform, with or without wheels, each	3 years
W4688	Single point cane for weights 251# to 500#	3 years
W4689	Quad cane for weights 251# to 500#	3 years
W4690	Underarm crutches for weights 251# to 500#	3 years
W4691	Fixed-height forearm crutches for weights to 600#	3 years
A4636	Replacement, handgrip, cane, crutch, or walker, each	6 months ages 0-20; 1 year 21 and over
A4637	Replacement tip, cane, crutch, walker, each	6 months ages 0-20; 1 year 21 and over
E0130	Walker, rigid (pickup), adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0135	Walker, folding (pickup), adjustable or fixed height	2 years ages 0-20;

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
		3 years 21 and over
E0141	Walker, rigid, wheeled, adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0143	Walker, folding, wheeled, adjustable or fixed height	2 years ages 0-20; 3 years 21 and over
E0148	Walker, heavy duty, without wheels, rigid or folding, any type, each	3 years
E0149	Walker, heavy duty, wheeled, rigid or folding, any type	3 years
E0154	Platform attachment, walker, each	2 years ages 0-20; 3 years 21 and over
E0155	Wheel attachment, rigid pick-up walker, per pair	3 years
E0156	Seat attachment, walker	3 years
E0158	Leg extensions for walker, per set of four (4)	3 years
W4695	Glides/skis for use with walker	2 years
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components	0-20 years only; 3 years
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components	0-20 years only; 3 years
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components	0-20 years only; 3 years
E0860	Traction equipment, over-door, cervical	3 years
E0705	Transfer device, any type, each	1 year ages 0-20; 3 years 21 and over
E0235	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	2 years
E1300	Whirlpool, portable (over-tub type)	2 years
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	3 years
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	3 years
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	3 years
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	3 years
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	3 years
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	3 years

HCPCS ®* Codes	Description	Lifetime Expectancy or Quantity Limitation
E2511	Speech generating software program, for personal computer or personal digital assistant	3 years
E2512	Accessory for speech generating device, mounting system	3 years
E2599	Accessory for speech generating device, not otherwise specified	2 years
V5336	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	$500 per year
E0637	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	Ages 0-20 only; 3 years
E0638	Standing frame/table system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels	Ages 0-20 only; 3 years
E0641	Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels	Ages 0-20 only; 3 years
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric	Ages 0-20 only; 3 years
E0240	Bath/shower chair, with or without wheels, any size	3 years
E0247	Transfer bench for tub or toilet with or without commode opening	3 years
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	3 years
W4016	Bath seat, pediatric (e.g., TLC)	3 years
E0700	Safety equipment, device or accessory, any type	3 years
E0163	Commode chair, mobile or stationary, with fixed arms	3 years
E0165	Commode chair, mobile or stationary, with detachable arms	3 years
E0167	Pail or pan for use with commode chair, replacement only	1 year
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type each	3 years
E0244	Raised toilet seat	3 years
K0739	Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	N/A
W4047	Miscellaneous for DME	N/A

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
Refer to https://medicaid.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment to for a current list of applicable ICD-10 Codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	06/21
Reviewed HCPCS codes. Added "Lifetime Expectancy or Quantity Limitation" column.	08/21	11/21
DELETED VERBIAGE FROM Specific Medical Necessity Criteria, section XI. Transcutaneous Electric Nerve Stimulation Devices, Bullet 6. "A statement from the physician, physician assistant, or nurse practitioner that the beneficiary has improved tolerance for activities of daily living with use of the TENS unit." Thus #7 became #6.	07/22	08/22
Reviewed HCPCS codes and "Lifetime Expectancy or Quantity Limitation" column; grammatical changes with no changes to criteria	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. HCPCS codes reviewed.	08/23	08/23

References

State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 5A-1 Physical Rehabilitation Equipment and Supplies. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published October 1, 2020. Accessed June 1, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay

the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.